ALABAMA BOARD OF MEDICAL EXAMINERS
NEWSLETTER

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Prescribing Controlled Substances

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Alabama Board of Medical Examiners

The public and physicians are alarmed about the increasing problems in our society with controlled substance abuse. The fear of prosecution has led many physicians to undertreat pain. Others, while treating patients in pain, have not been fully aware of the ramifications of treating these patients. The Board of Medical Examiners published guidelines that outline reasonable approaches to manging patients in pain. These guidelines follow Alabama law concerning administration of controlled substances for pain management.

There are several thoughts that must be addressed in the treatment of any patient with controlled substances.

- What type of pain are you treating: acute pain, pain associated with a malignant condition, or chronic non-malignant pain?
- Is a narcotic necessary for pain relief or will another type of analgesic suffice?
- What is the cause of the pain? Do you have a diagnosis?
- Chronic non-malignant pain is a chronic disease, like diabetes, hypertension, renal disease, etc. Just as you take a good history and physical examination, do appropriate laboratory evaluations and x-rays, get appropriate counsults and decide on and initiate proper treatment for these diseases, so should you evaluate a chronic pain patient. And, just as you monitor the diabetic, hypertensive, or other patient with a chronic disease, so should you monitor one with chronic pain: by establishing a plan, setting goals for treatment to accomplish, assessing treatment progress, establishing treatment levels, searching for reasons for treatment failure and encouraging patient participation in their treatment. Treatment of chronic disease is more than treatment of symptoms only.
- Look for coexistent diseases but avoid treating a myriad of symptoms by use of multiple drugs unless indicated by your evaluation.

DOCUMENT! DOCUMENT! DOCUMENT! With the problems we have today with misuse, abuse and diversion of medically prescribed controlled substances, it is imperative that you document your records completely. Treatment

see Prescribing page two

A Duty to Report

By Gregory E. Skipper, M.D., FASAM
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What are you supposed to do if you are aware of a fellow physician who is grossly impaired? You may or may not know the cause. It could be alcohol or drugs. It could be depression or other types of mental illness. The situation might involve an associate who was incoherent while on call. It might involve an acquaintance that is so depressed he's stopped making rounds on hospitalized patients. Should you ignore the impairment? Should you cover for your colleague? What is your duty?

According to state law 34-24-361b (affectionately referred to as the "snitch law"), "Any physician …in … Alabama … is hereby required to… report to the board or the commission any information …which appears to show that any physician … may be guilty of any of the acts, offenses or conditions set out in Section 34-24-360." This section lists causes of action in which a physician is either impaired "by reason of illness, inebriation, excessive use of drugs, narcotics, alcohol, chemicals or any other substance, or as a result of any mental or physical condition" or has committed a crime, gross negligence, or ethical violation. In 1991

see Duty page four

Prescribing *continued*

of non-malignant pain patients should be as meticulously described and documented as a surgeon does for surgery. The surgeon records a history, examination, and working diagnosis, then orders appropriate tests and consultations, recording these before surgery. Discussions with the patient and family, if necessary, are recorded. The surgeon then fully describes the operative procedure and each post-operative visit. Do the same for chronic pain patients. Some other issues to address are:

- Never give a prescription for controlled substances to someone other than the patient unless you have absolute knowledge that the prescription will not be diverted. In these cases, follow-up with the pharmacy to verify that the medication was correctly filled.
- Use your local pharmacists to alert you when your patient is receiving controlled substances from multiple physicians. Better that the pharmacist alerts you than the Board. You must cultivate relationships with your pharmacists.
- Do not prescribe more controlled drugs than are needed between visits.
- Be careful of using drugs that are not compatible or that may be synergistic in addictive properties.
- Keep a flow record of each visits of your patients, just as you do for blood pressure, blood sugars, etc.

Documentation

In the current practice of medicine one hears over and over "document; document." There are reasons for that in the current medical climate. Many of us who began practice thirty or forty years ago kept short records, often on index cards and in a personal shorthand, as a reminder and reference for us when the patient returned. Now, more detailed and inclusive records are required because our society is more mobile. A large percentage of the population moves each year and we are less likely to see the same patients year after year. As patients move from place to place and physician to physician, the medical records are a biography of their health. It is helpful for new physicians to know how the patient has been treated and previous plans for the future.

Physicians should confirm a new pain patient's diagnosis, either by obtaining old records or by performing the necessary diagnostic tests. It is reasonable to give the new patient the benefit of the doubt on the initial visit and prescribe a 2-3 week supply of pain medication; however, if the patient does not comply with your attempts to verify the diagnosis, you should discontinue providing controlled substances until you are able to obtain objective data confirming the patient's indication of opioids.

Treatments are more complex today than five decades ago. Instead of a PDR with a couple of hundred pages, we have one with more than three thousand, and that does not include all the drugs available. Technology has produced more ways to assess medical conditions: in the laboratory; with radiology; with ultrasound; with radioisotopes; with new surgical techniques and endoscopy. For a full patient health review, more record keeping is needed.

Medico-legal concerns are best addressed with good documentation. This should reflect what you did and your thoughts about why you did it.

But, in attempting to have adequately descriptive records, you must be sure that you have *accurate* records. To assist in record keeping, some physicians are using computer-generated records. These help record history, physical findings, laboratory testing and medications prescribed. But, when these are entered, it is the physician's obligation to make certain that what is recorded is accurate and that what is recorded is what was done. With check-off templates, etc., it is easy to have the computer record a full physical exam of a system when only a portion of it was done on that visit.

Treating family members

In years past it was the usual practice for a physician to treat his family, because he was the only physician in the area, it was expected that you cared for your own, except in unusual cases, and because treatment modalities were less complex and there were fewer specialists available.

The AMA Handbook on Ethics makes the following statement about treating family members. "E-8. 19 Self-Treatment or Treatment of Immediate Family Members . . . Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members." (I, II, IV) Issued June 1993.

Essentially, physicians may treat family members for minor illnesses, but for chronic or complex illness, while they may assume care, such treatment would raise the question, of the physician's good judgment. What is absolutely contraindicated is prescribing controlled substances to family members. An exception may be an emergency short-term treatment when the physician can document the need for the medication and the lack of another physician to provide treatment. A further question is how close a relationship constitutes a family member. Obviously, a first generation relationship is family as is a second generation of the same bloodline. When cousins, in-laws, etc., are involved, the general rule should be physician judgment, that is, whether he can truly treat the patient objectively without regard for the family relationship. ■

Alabama Board of Medical Examiners
PUBLIC ACTION REPORT
October through December, 2001

On October 9, 2001, based upon the stipulation of the parties, the Board entered an Order reprimanding the license to practice as a physician assistant in Alabama of Derrick Michael Johnson, P.A., license number PA-162, Montgomery AL.

On October 17, 2001, based upon the stipulation of the parties, the Board entered an Order reprimanding the license to practice as a physician assistant in Alabama of Jeffery Lee Bergstresser, P.A., license number PA-181, Madison AL.

On October 17, 2001, based upon the stipulation of the parties, the Board entered an Order reprimanding the license to practice as a physician assistant in Alabama of Tammie Shawanna Smith, P.A., license number PA-96, Huntsville AL.

On October 17, 2001, the Board issued an Order restoring the license to practice medicine in Alabama of Dennis L. Olive, M. D., license number 12526, Huntsville AL, to full, unrestricted status.

On December 21, 2001, the Board entered an Order removing the voluntary restriction attached to the certificate of qualification and license to practice medicine in Alabama of Nathan B. Collier, M. D., license number 7913, Gadsden AL. Dr. Collier now possesses a full, unrestricted certificate of qualification and license to practice medicine in Alabama. ■

Medical Licensure Commission
PUBLIC ACTION REPORT
October through December 2001

On October 1, 2001, the Commission entered an Order terminating all restrictions on the license to practice medicine in Alabama of Donald P. McCurdy, M. D., license number 17085, Birmingham AL, and restoring the license to full, unrestricted status.

On October 1, 2001, the Commission entered an Order revoking the license to practice medicine in Alabama of Bruce H. Brennaman, M. D., license number 18575, Columbus GA.

On October 24, 2001, the Commission entered an Order temporarily suspending the license to practice medicine in Alabama of Anibal F. Heredia, M. D., license number 6371, Montgomery, AL.

On October 25, 2001, the Commission entered an Order temporarily suspending the license to practice medicine in Alabama of Frances D. Salter, M. D., license number 12252, Atmore, AL. Dr. Salter is ordered to cease and desist from the practice of medicine in the state of Alabama until such time as the Administrative Complaint of the Alabama State Board of Medical Examiners shall be heard by the Commission and a decision rendered thereon.

On November 1, 2001, the Commission entered an Order revoking the license to practice medicine in Alabama of Ivan Lewis Slavich, D. O., license number DO-222, Valley AL. Dr. Slavich is no longer authorized to practice medicine in Alabama.

On November 1, 2001, the Commission entered an Order reprimanding the license to practice medicine in Alabama of Dick Owens, M. D., license number 7870, Haleyville AL, and assessing an administrative fine.

On November 1, 2001, the Commission entered an Order revoking the license to practice medicine in Alabama of William Earl Thornton, M. D., license number 19258, Las Vegas NV. Dr. Thornton is no longer authorized to practice medicine in Alabama.

On November 1, 2001, the Commission entered an Order revoking the license to practice medicine in Alabama of Charles L. McCullouch, Jr., M. D., license number 18283, Memphis TN. Dr. McCullouch is no longer authorized to practice medicine in Alabama.

On November 1, 2001, the Commission entered an Order reinstating the license to practice medicine in Alabama of Allan C. Walls, M. D., license number 17151, Huntsville AL, subject to certain terms and conditions.

On December 10, 2001, the Commission entered an Order issuing a license to practice medicine in Alabama to Victoria Lochiel Woods Anderson, M. D., license number 14888, Mobile AL, subject to certain conditions.

On December 28, 2001, the Commission entered an Order denying the request to terminate the probationary status of Wyndol S. Hamer, M. D., license number 9756, Tuscumbia AL.

On December 28, 2001, the Commission entered an Order reinstating the license to practice medicine in Alabama of William S. Warr, M. D., license number 2244, Phenix City AL, to full, unrestricted status.

On December 28, 2001, the Commission entered an Order placing on probation the license to practice medicine in Alabama of Richard A. Walker, M. D., license number 8026, Birmingham AL.

On December 28, 2001, the Commission entered an Order suspending license to practice medicine in Alabama of David M. Connelly, M. D., license number 6880, Montgomery AL.

On December 28, 2001, the Commission entered an Order denying the application for reinstatement of the license to practice medicine in Alabama of Bruce H. Brennaman, M. D., license number 18575, Cataula GA. ■

Duty *continued*

the law that created the Alabama Physician Health Program, APHP, included a section (34-24-405) that specified that a report to the APHP "shall be deemed to be a report to the board of medical examiners for the purposes of any mandated reporting of physician impairment otherwise provided for by the statutes…." The law further states that any physician who makes such a report "shall not be liable to any person for any statement or opinion made in such report."

The intent of these laws seems to be to set an ethical standard requiring reporting of a physician who is impaired when safety of patients or the health of the physician is in jeopardy. This is a good law. Physicians are in a unique position to observe their colleagues and should feel an obligation in this regard to protect patients from potential harm. This is comparable to the law requiring reporting of child abuse, elder abuse, or known homicidal ideation by a patient. Reporting is responsible and protective of patient rights and also serves the well-being of the physician involved. Also, according to the law, the reporting physician is protected from liability.

If suspected impairment is reported to the APHP confidentiality is maintained. A therapeutic rehabilitative approach is taken to evaluate what problems, if any, are present and how they may be treated. If you are concerned about an impaired colleague call APHP at 334 954-2596. ■

The Alabama State Board of
Medical Examiners
and Medical Licensure Commission
of Alabama
invite you to visit our web site at:

www.albme.org

and obtain:

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"Docfinder" (a searchable database)

Disciplinary Actions (Updated monthly)

Administrative Rules & Regulations

Policy Opinions

Alabama Statutes

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Alabama Board of Medical Examiners NEWSLETTER is published quarterly for physicians who hold a license to practice medicine or osteopathy in the state of Alabama. The newsletter is designed to keep the licensed physicians of Alabama updated as to developments in the regulation of the practice of medicine in this state. The Board welcomes your comments, questions or other input.

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